STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING _____ B. WING _____	C 06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00108997, IN00109267 and IN00109427. This visit was in conjunction with a Post Survey Revisit (P.S.R.) to the Investigation of Complaints IN00107297 and IN00107575 completed on 05/07/2012. Complaints IN00108997, IN00109267, and IN00109427 - Substantiated. No deficiencies related to the allegations are cited. Survey date: June 11, 12, 13, 14, 2012 Facility number: 000195 Provider number: 155298 AIM number: 100267690 Survey team: Charles Stevenson RN Christi Davidson, RN (6/11/12) Census bed type: SNF/NF: 77 Total: 77 Census payor type: Medicare: 6 Medicaid: 57 Other: 14 Total: 77 Sample: 8 Cambridge Manor Nursing and Rehabilitation Center was found to be in compliance with 42 CFR part 483, subpart B and 410 IAC 16.2 in	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING _____ B. WING _____	C 06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	**8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 regard to the Investigation of Complaints IN00108997, IN00109267 and IN00109427. Quality review 6/18/12 by Suzanne Williams, RN	F 000		